STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E594	A. BUILDING 00 B. WING	06/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCGIVNEY HEALTH CARE CENTER	2907 E 136TH ST CARMEL, IN 46033

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F000000	This visit was for the Recertification and Licensure Survey. This visit included the Investigation of Complaint IN00128302. Complaint IN00128302- Unsubstantiated due to lack of evidence. Survey dates : June 12, 13, 14, 17, 18, and 19, 2013. Facility number: 000545 Provider number: 15E594 AIM number: N/A Survey team: Michelle Hosteter, RN-TC Gloria Bond, RN (June 14, 17, 18, and 19, 2013) Janet Stanton, RN (June 12, 13, and 14, 2013) Census bed type: NF : 35 Total : 35 Census payor type: Medicaid : 34 Other: 1 Total : 35 These deficiencies reflect State	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review was completed by Tammy Alley RN on June 26, 2013.			

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F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide support services to a resident with depression for 1 of 1 resident in a sample of 10 residents reviewed for unnecessary drugs. (Resident #16) Findings include: Record review for Resident # 16 was completed 6/18/13 at 9:30 a.m. Diagnoses included, but were not limited to, cerebral palsy, depression, psychosis, constipation, non-malignant brain tumor, bells palsy, and insomnia. The Social Services Director (SSD) progress notes indicated, "...12/14/12 resident indicated she told CNA she wanted to die. She does not have a plan to harm herself, but the Director Of Nursing and SSD requested 15 minute checks and will have SSD monitor and visit often with resident to provide assist and encouragement...." There was no documentation in the progress notes indicating follow-up with the resident after this date.	F000250	Disclaimer : preparation, submission, and implementation of this Plan of Correction does not constitute an admission of/or agreement with the findings of this survey. McGivney Health Care reserves the right to contest the survey findings through the informal dispute resolution, formal appeal proceedings or any adminitrative or legal proceedings. The facility offers its responses, credible allegations of compliance, and plan of correction as part of on going efforts to provide quality care. McGivney Health Care Center reserves the right to modify policies, procedures, and quality improvement systems as necessary to better meet the needs of the residents and facility. 1.Resident # 16 was re-interviewed by Social Services on 7/08/2013. Careplans and Behavior Grids pertaining to this resident (Resident #16) have been updated and implemented to reflect current depression status. Resident #16 has been placed on "Alert Charting" through the Electronic Charting System (ECS) for period including but not limited to 30 days. The consulting	07/26/2013

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	The care plan dated 4/30/13 indicated, "...Social Services will have 1:1 visits assess cognitive status assess/monitor for behavior changes, including agitation, anxiety, aggression, delusions, hallucinations, and/or decreased inhibitions. Assess for signs./symptoms of depression encourage resident to express feelings regarding current situation and anticipated changes...." A recent psychiatrist note dated 6/5/13 indicated, "... patient alert and oriented time 3 and reported to physician she is consistently depressed mood, poor sleep, and decreased appetite and possible visual hallucinations...." The physician increased her Zoloft (depression medication) to 200 milligrams and will continue to follow with behavior monitoring and management and psychological concerns. In an interview with Resident # 16 on 6/17/13 at 10:30 a.m., she indicated she was just so depressed all the time and didn't know why she wasn't feeling any better. She indicated once when she was in the hospital they put her on a medication that helped, but she didn't know what it		psychologist was contacted on 7/8/2013 and a visit was scheduled. 2. All residents have the potential to be affected by this deficient practice. Audits will be conducted by 07/26/2013 on the behavior grids to ensure that no other residents were or are affected by this practice. 3. Behavior grids will be reviewed weekly during normal business hours. Follow up alert charting will be triggered in ECS on an as needed basis by the DON/Social Service/Designee. In-services will be conducted on Behavior Tracking Grids and Alert Charting Processes. Lacy Beyl & Company has been contacted and will be here on 07/10/2013 to provide consulting and supportative services to Social Services Designee in regards to our Behavior Monitoring Program. Monthly meetings will be held with Medical Director and Psychologist to review individual behaviors, current interventions, and medication effectiveness. Individualized adjustments to medications will be made on an as needed basis. 4. Findings will be brought to monthly QAA meetings for 6 months and then on a quarterly basis x 6 months or until deemed unnecessary by the IDT Team and/or Medical Director. 5 DOC: 07/26/2013	

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	was. She said she had talked to people about it, but doesn't know what is going on. In an interview with the Social Services Director (SSD) on 6/18/13 at 9:50 a.m., she indicated ECS (electronic computer record system) was where she noted information related to depression symptoms and assistance for Resident # 16. She also indicated this resident had talked with her and had discussed wanting to move in with cousin at the last care plan meeting. She indicated this did not happen. She indicated within last month Resident #16 had become more depressed after finding this out. The mother told the SSD the resident had attention seeking behaviors through displaying depressive symptoms. There was no documentation located in the Social Service notes in ECS or in the clinical record relating to her symptoms, care or treatment of the resident's depression. 3.1-34(a)(2)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to follow the care plan interventions for 2 of 24 residents reviewed for care plans in a sample of 24. (Resident # 3 and Resident #26) Findings include: 1. Record review for Resident #3 was completed on 6/16/13 at 3 P.M. Diagnoses included, but were not limited to, end stage multiple sclerosis, depression, and constipation. The care plan for Nutrition dated 4/23/13, indicated the Certified Nurse Aids (CNA) were to monitor intake and output every shift . A document titled CNA intake record for 3/13/13- (blank) indicated, "... A.M. shift totals 1 day ago 680, 3 days ago 440, 5 days ago 360, 7 days ago 1080...P.M. shift totals 1 day ago 0, Night shift totals was left blank...." In an interview with the Director of	F000282	1. Resident # 3 Careplan Update and Intake/ Output Careplan Updated. Resident #26 Careplan Update for Behavior. Resident 26 Behavior Grid Updated to reflect current status. 2. All residents have the potential to be affected by this deficient practice. Care Plan and Behavior Audits were conducted to ensure that others residents were not affected by this practice.3. In-services will be conducted on proper Electronic Charting System (ECS) processes including intake/output and behavior monitor program. Lacy Beyl & Company was contacted and scheduled to provide consulting and supportative services to Social Service Designee. 4. Monitoring of the Behavior Grids will be conducted on a daily basis during normal business hours (Monday thru Friday) by the Social Service Designee to ensure proper documentation. Behavior Grids will be monitored week-ends and off hours by charge nurses to ensure adjustments and implementation of Care Plans. Care plan adjustments will be completed as they pertain to behaviors on an as needed basis. ESC	07/26/2013

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	Nursing on 6/19/13 at 9 A.M., she indicated the CNA's (Certified Nursing Aid) had not been documenting intake and output as they should. 2. The record review for Resident #26 was completed on 6/18/13 at 2 P.M. Diagnoses included, but were not limited to, recurrent depressive psychosis, dementia with behavior disturbances, diabetes, chronic pain, high blood pressure, asthma, delusions, dyshpagia, and arthritis. A care plan dated 5/22/13 indicated, "... resident had a history of yelling at staff when she did not want to follow thru with activities of daily living care. Nurses-Administer medications as ordered, assess for effectiveness and adverse effects identify patterns of behavior, offer food and fluids assess/treat pain. Nurse aids- Record behaviors, maintain safety of resident and others. report pain indicators...." There were no behavior tracking records located in the clinical record. In an interview with the Director of Nursing on 6/13/13 at 1:30 P.M., she indicated the facility did not have a good system in place to track specific behaviors.		documenation will be reviewed on a daily basis during normal business hours (Monday thru Friday) to ensure accuracy and completion of intake/output by DON/Designee. 5. Results will be brought to monthly QAA meetings for 6 months and on a Quarterly basis x 6 months thereafter until deemed unnecessary by IDT / Medical Director .6. DOC 07/26/2013	

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	3.1-35(g)(2)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure bowel montiorin was completed to prevent constipation for 2 of 10 residents reviewed for bowel monitoring in a sample of 10. (Resident #10 and Resident #29) Findings include: 1. The record review for Resident #10 was completed on 6/17/13 at 2 P.M. Diagnoses included, but were not limited to, schizoaffective, diabetes, bipolar, breathing problems, heart failure, degenerative disc disease, hypothyroidism, obesity, and dementia. The Medication Administration Record (MAR) indicated an order for Milk of Magnesia and Fleets enema as needed for constipation. The MAR's for April through June 2013 indicated he had not received any as	F000309	1. Resident # 10 and Resident # 29 had bowel assessments completed. Resident # 10 and Resident #29 had medication regimens reviewed to ensure appropriate medication to facilitate bowel movements at least every 3 days. 2. All residents have the potential to be affected by this deficient practice. An Audit was conducted to ensure no other residents were affected by this practice. Individualized adjustments to be made PRN in regards to any findings during these audits. 3. All Nursing staff was in-serviced on Bowel Protocol. Nurses will track bowel movements by utilizing the ECS reports daily and prepare a list of residents requiring medication for bowel elimination. Nurses will check charting on bowel elimination prior to C.N.A's shift ending. DON/Designee will obtain and review Bowel List on daily basis during normal business hours (Monday thru Friday), Weekends will be mointored by Day Charge Nurse to ensure every 3 day pattern. These reports will be	07/26/2013

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	needed medication for constipation. The care plan dated 12/5/12 indicated, "...-Problem-psychotropic drugs- Nurses, monitor for adverse effects (sedation, dry mouth, constipation,urinary tretention ataxia, etc.) Notify physician of symptoms and request pharmacy review of drug regimen as needed, request psych consult as needed...." The bowel records for March through June of 2013 indicated the resident did not have a bowel movement for more than 3 days on April 9-April 17, April 19-25, April 27-April 30, May 11-May 14, and June 9-June 17. 2. Resident #29's record was reviewed on 6/17/2013 at 3:00 P.M. Diagnoses included, but were not limited to, dementia, osteopenia, anemia, constipation. The care plan dated 1/21/2013 and updated 6/4/2013,indicated a problem with constipation with approaches that included, but were not limited to, administer medications as ordered and assess for effectiveness.		reviewed on Monday Mornings by Director of Nursing / Designee to ensure Bowel Protocol documentation was completed. Medications will be adjusted on an individualized basis as deemed necessary. Any resident going 3 days without bowel elimination will be offered medication to promote adequate (BM every three days) bowel functions. Medications will be adjusted on individualized basis as needed. 4. Results will be taken to monthly QAA meetings for 6 months and Quarterly x 3 months thereafter or until deemed unnecessary by IDT/ Medical Director.5. DOC 07/26/2013	

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	The bowel history record for Resident #29 indicated, he had no bowel movements for more than 3 days on the following dates: 5/6/2013 to 5/16/2013, 5/20/2013 to 6/5/2013, and 6/12/2013 to 6/15/2013. The June 2013 MAR indicated Resident #29 had two medications ordered for constipation as needed. There was no indication of these medications being administered. In an interview with the Director of Nursing on 6/18/2013 at 2 P.M., she indicated she was aware there was a problem with as needed medications for constipation not being administered as the physician ordered. 3.1-37(a)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure monitoring for antipsychotic medications was completed including Gradual Dose Reduction (GDR) for 2 of 10 residents reviewed for unnecessary medications in a sample of 10. (Resident # 16 and Resident #10) Findings include: 1. Record review for Resident # 16	F000329	1. Resident # 16 medications were reviewed with Medical Director and medication adjustments implemented as necessary. Behavior grids for Resident #10 were updated to reflect current status. Resident # 10 was placed on alert charting in ECS with 30 days of symptom tracking related to use of antipsychotic useage. 2. All residents have the potential to be affected by this deficient practice. An Audit was conducted with supportative documentation to provide for all declination. The	07/26/2013

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	was completed 6/18/13 at 9:30 a.m. Diagnoses included, but were not limited to, cerebral palsy, depression, psychosis, constipation, non-malignant brain tumor, bells palsy, and insomnia. The physician's progress note dated 9/25/12 indicated the resident was having increased anxiety. There was no documentation in the clinical record regarding behavior of anxiety. The MDS (Minimum Data Set) assessment dated 5/11/13, indicated the resident was moderately cognitively impaired, mildly depressed, and had no behaviors. The care plan dated 4/30/13 indicated, "...Cognitive loss. Nurses to Monitor effectiveness and potential adverse effects of medications. Assure adequate pain control, assess/monitor for behavior changes, [includes agitation, anxiety, aggression, delusions, hallucinations, and /or decreased inhibitions]...." A pharmacy recommendation dated 5/13/13 requested the physician to reduce Xanax 0.5 milligrams (anti-anxiety medication) due to the resident had been taking the		Medical Director and Consulting Psychologist have been in-serviced on State Regulations regarding the appropriate Gradual Dose Reduction Documention. In-service will be conducted for all Nursing staff on Behavior Monitoring Program. Lacy Beyl & Company scheduled for visit on 07/10/2013 to provide supportative services regarding behavior tracking and Gradual Dose Reduction. 3. Behavior Grids will be reviewed on daily basis during normal business hours (Monday thru Friday) by the Social Services at the morning stand up meetings. Monthly Behavior Meetings will be held to ensure proper Gradual Dose Reduction tracking and completion of supportative documenation. The monthly behavior meetings will include but not limited to Social Service Designee, DON, Medical Director, Consulting Psychologist, and Consulting Pharmacist to generate and track the Gradual Dose Reduction on a individualized basis. 4. Findings will be brought monthly to QAA meetings for 6 months and Quarterly thereafter x6 months until deemed unnecessary. 5. DOC : 07/26/2013	

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	medication since 5/11/12 for anxiety. The GDR (gradual dose reduction) request was marked as declined by the physician but no explanation given as to why it was not reduced. There was no documentation in the record for tracking of behaviors related to anxiety. 2. The record review for Resident #10 was completed on 6/17/13 at 2 P.M. Diagnoses, included, but were not limited to, schizoaffective, diabetes, bipolar, hypothyroidism, obesity, and dementia. The MDS (Minimum Data Set) assessment dated 4/18/13 indicated the resident had severe cognitive impairment. The Care plan dated 11/29/12, indicated, "... ADL-self care deficit and physiologic aging changes depression, chronic illness fatigue dementia. Approach 6/3/13-Nurses-Assess functional level monitor for effects of medication on daily function, assure safety, support adequate rest periods, review lab results, assess for signs and symptoms of depression, assess for			

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	behavior changes, encourage socialization, provide adequate pain control. Nurse aide to have call light in reach, encourage independence, encourage tasks in smaller segments, as needed...." The psychiatrist progress notes indicated a physician's order dated 8/28/2012 for Seroquel XR 50 mg (antipsychotic medication) 1 tab every day and it was discontinued 3/25/13. The psychiatrist progress notes indicated a physician's order dated 2/15/13 indicated an order for Zyprexa (antipsychotic medication) 20 mg 1 tab daily. The record lacked documentation of behavior tracking for the use of the above medications. In an interview with the Director of Nursing on 6/13/13 at 1:30 p.m. she indicated the facility did not have a good system in place to track specific behaviors. 3.1-48(a)(3)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E594	A. BUILDING 00 B. WING	06/19/2013

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure narcotics were double locked for 1 of 1 medication refrigerators in 1 of 1	F000431	1. The 2 bottles of liquid Lorazepam were immediately placed behind double locks. 2. All residents have the potential to be affected by this deficient	07/26/2013

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	medication rooms. This deficit practice had the potential to affect 35 of 35 residents residing in the facility. Findings include: The medication storage tour was completed with the Director of Nursing on 6/19/13 at 12:40 P.M. The following was observed in the refrigerator that was not locked: Two plastic bottles of liquid Lorazepam (anti-anxiety medication). 15 vials of Lorazepam (an antianxiety narcotic medication) 1 mg injectable solution. In an interview on 6/19/13 at 12:45 P.M., RN # 1 indicated the narcotics should be stored in double locked area. In an interview with the Director of Nursing on 6/19/13 at 12:46 P.M., she indicated she thought as long as it was behind the locked door of the medication room it was all right. She indicated they do not have any policy for storage of medications. 3.1-25(m)		practice. An Audit was conducted to ensure proper storage of narcotics in facility. An In-Service was conducted for all licensed nursing staff . 3. Director of Nursing/ Designee will check on a daily basis during normal business hours (Monday thru Friday) for appropriate storage. Administrator will randomly observe narcotic storage 2x weekly to ensure proper storage alternating during shift count. 4. Findings will be brought to monthly QAA meetings x3 months and Quarterly x9 months or until deemed unnecessary by IDT Team or Medical Director. 5. DOC 07/26/2013	

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F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to	F000441	1. No residents were found to be affected. 2. All residents have	07/26/2013

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	implement an infection control program which included tracking, trending, and follow-up concerning any infectious patterns. This deficient practice had the potential to impact 35 of 35 residents residing in the facility Findings included: During an interview with the Director of Nursing on 6/17/2013 at 10:30 A.M., she indicated, she had been back as the Director of Nursing for about a month and had not been able to find the infection control tracking record and did not know if there was one to be found. 3.1-18(b)(1)(A) 3.1-18(b)(1)(B) 3.1-18(b)(1)(C)		potential to be affected. 3. It is the practice of the facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent development and transmission of disease and infection. Director of Nursing / Designee will investigate, track, and trend all antibiotic use and infectious diagnoses. If any patterns and outbreaks are identified, the findings will be reported to the appropriate regulatory agencies. Tracking will be completed using current physician orders, monthly lab reports, and pharmacy reports. Director of Nursing will alert the Administrator immediately if findings warrant notification to regulatory agencies. 4. Findings to be brought to monthly QAA meetings x 6 months and Quarterly thereafter x6 months or until deemed unnecessary by IDT Team or Medical Director 5. DOC: 07/26/2013	